Editorial

In a context of intense focus on the economic and financial difficulties facing the country, the Irish health system remains one of the few issues capable of taking centre stage in media and public discussion. We now find ourselves faced with not just the kind of health service crises that have characterised the past two decades but with new problems arising from the fact that the recession itself will have a major 'health impact'.

On the one hand, poverty and financial worries, anxiety about the future, and the stresses associated with joblessness are all likely to take a serious toll on people's health. On the other, the need to address the deficit in the public finances will mean it will be harder and harder to sustain, let alone improve, health service provision.

This, then, hardly seems an opportune time to advocate radical reform of the health system. Yet the now oft-quoted comment of White House Chief of Staff, Rahm Emanuel, 'never let a good crisis go to waste', is a reminder that economic and social upheaval can bring an openness to critically assess existing policies and practices and to explore alternative approaches that previously might have been dismissed as unworkable or politically unacceptable.

Two of the contributors to this issue of *Working Notes*, Sara Burke and Fergus O'Ferrall, suggest that the economic and social crisis could provide the impetus to institute far-reaching change in the financing and delivery of health care in Ireland. They emphasise the need to seize the opportunity to finally move away from the current inequitable and inefficient two-tier structure and put in place a system of universal health care with equal access for all based on need, not income. Another of our contributors, Gerry O'Hanlon SJ, is also clear that change is required and says, 'Our two-tier system in Ireland is a scandal: it offends against justice and the socially inclusive practice of Jesus Christ, and it requires radical reform.'

So is there any likelihood that this time of opportunity as well as crisis will be grasped? It is clear that the economic downturn in Ireland is forcing, however slowly, acknowledgment of policy failures across a range of issues during the past decade. There is already a growing recognition that a long period of unprecedented wealth has slipped past without achieving the degree of progress in terms of social justice that could readily have been realised.

The publication in late April by Fine Gael of a health reform strategy including a proposal for a system of universal health insurance means that all of the opposition political parties represented in the Dáil have now declared their commitment to ending the two-tier system of health care – though the specific mechanisms by which they would seek to achieve this goal differ.

So far, the parties in government have given no indication of an intention to embark on a process that could lead to a single-tier health system. However, a statement included in the announcement in early April of the establishment by the Minister for Health and Children, Mary Harney TD, of the Expert Group on the Allocation of Resources in the Health Sector is worth noting. The statement says that it is not part of the Group's remit to examine 'whether we finance healthcare through taxation or compulsory private or social insurance'. It then goes on to say: 'However, if the very method by which finance is raised is shown by the Group to influence the best allocation of a given level of resources for the outcomes we want, then the Group is asked to make recommendations in that respect'. It will be interesting to see the outcome of the Group's deliberations on this issue.

Over the years, official policy statements have consistently proclaimed that 'equity' is to be a core value underpinning Irish health care, while at the same time putting forward a rationale for the continuance, albeit with some improvements and reforms, of the two-tier system.

Perhaps this time of crisis in Ireland will see the emergence of a commitment, by both public and politicians, to finally move beyond the limited aspirations we have had for health care in this country and put in place a truly fair as well as efficient health system.

Some Christian Perspectives on Health and Sickness

Gerry O'Hanlon SJ

Introduction

'There's nowt so queer as folk' – this, now non-politically correct, maxim from the North of England applies pretty well to the common human experience of taking good health for granted, while becoming anxious at the onset of illness. But, of course, there may be good reason for such anxiety – even minor ill-health causes inconvenience and loss of energy, while major illness, chronic or acute, brings great suffering and raises serious life and death questions. In what follows, I want to propose some Christian perspectives on health and sickness that may help to address some of the questions that arise at both a personal and a societal level.

Jesus Christ and Health and Sickness

We are not told if Jesus ever caught a cold or suffered from a migraine. We do know, however, that he experienced human weakness; that 'he was like us in all things except sin' (Hebrews 4: 15); that he wept at the news of the death of his friend Lazarus; that, in one version of Luke, in his anguish at Gethsemane 'his sweat fell to the ground like great drops of blood' (Lk. 22: 43–44).

Moreover, we do also know that when he preached his central message of the coming of the Kingdom of God, he accompanied it with many miraculous healings. When the disciples of John the Baptist came to enquire if he really was the Messiah, he answered by saying: 'Go back and tell John what you have seen and heard: the blind see again, the lame walk, lepers are cleansed, and the deaf hear …' (Lk.7: 22). And he could also have mentioned the healing of the many people the society of the time deemed to have 'evil spirits', who we may conjecture were suffering from mental illnesses of various kinds or epilepsy.

Healing Ministry of Jesus

There are several aspects to the healing practice of Jesus that give us an insight into his – and so, we believe, God's – attitude to health and sickness.

Compassion

First, Jesus always agrees to heal, and we are often told that he does so because he has compassion. Of course, one might say, this is only what could be expected: if he was a good person, if he had this power, then why not? But there is a deeper layer of meaning involved here. Jesus is implicitly telling us that our salvation, that deep friendship with and love of God which is our destiny, that 'life to the full', includes physical and mental health as values to be cherished. Ill-health, then, is at least a pre-moral evil, and is to be avoided.

This attitude is a far cry from a notion of salvation that is purely spiritual, or, indeed, from a notion of illness (present in parts of the Old Testament tradition) as a punishment from God – 'Rabbi, who sinned, this man or his parents, for him to have been born blind?' 'Neither he nor his parents sinned', Jesus answered (Jn. 9: 1–2). Of course, we may bear some responsibility for illnesses which afflict us – individually because, for example, of our choice of poor diet or lack of exercise; communally, for example, because of our creation of a hazardous environment or our tolerance of social and economic conditions that damage health. But good people sometimes needlessly compound their own anxiety with the often unspoken notion that their illness is due to the fact that God is 'out to get them'. Nothing could be further from the attitude of Jesus in the Gospels. Jesus wants to heal and it is part of his mission to his disciples that they continue his ministry of healing.

Need

Secondly, it is clear that the ministry of healing which Jesus exercises is conditioned by need, not by class, nationality, or ability to pay. We can suppose that those he healed were mostly poor: this, of course, was the largest social group at the time, and the group with which Jesus most identifies. Nonetheless, he is not deaf to the plea of the synagogue official, or to the faith of the Roman centurion. The only time that Jesus even questions this universal, inclusive approach is in relation to his encounter with the Syrophoenician woman whose daughter had 'an unclean spirit' (Mk. 7: 24–30) but, perhaps learning from the insistent need of the woman herself, he decides firmly in her favour and in favour of inclusivity.

The Kingdom

Thirdly, the Kingdom that Jesus preaches is to come in the future and yet is already among us. Theologians use the term eschatological to express this reality: the fullness has yet to come, but there are anticipations, given as a pledge of that fullness, already present. Jesus, then, did not cure everyone who lived in Palestine in his day. In fact, according to St Paul, sickness and weakness may sometimes have a beneficial effect in God's plan for us: '… I was given a thorn in the flesh … about this thing I have pleaded with the Lord three times for it to leave me, but he has said, "My grace is enough for you: my power is at its best in weakness" … so I shall be very happy to make my weakness my special boast … for it is when I am weak that I am strong' (2 Cor. 12: 7–10).

It is clear that the ministry of healing which Jesus exercises is conditioned by need, not by class, nationality, or ability to pay

This surprising slant on what we spontaneously view as negative is quite often borne out in our experience, and not just in a faith that 'hopes against hope'. So, for example, you will hear someone who has recovered from a serious illness express the conviction that now they appreciate life in an altogether different, more profound way, while others will testify to the life-changing experience of being loved as never before in their situation of illness and vulnerability.

This perspective is reinforced by the remark elsewhere in Paul that 'it makes me happy to suffer for you, as I am suffering now, and in my own body to do what I can to make up all that has still to be undergone by Christ for the sake of his body, the Church' (Colossians 1: 24). This line of thought is re-captured in the intuition of Martin Luther King that 'unearned suffering is redemptive' – the intuition that at the heart of the world is a struggle between good and evil which only a redemptive love involving sacrifice and suffering can resolve, that Jesus Christ is the one who brings about this resolution, but that, graciously, he has allowed us a part in this resolution through our own offerings of a love that will sometimes suffer.

This third aspect makes it clear that sickness, and even death, are best understood according to the premise of St Augustine's theodicy that God 'judged it better to bring good out of evil than not to permit evil to exist at all'.[1] Nonetheless, there is real negativity here, at least a pre-moral, physical evil, and the predominant tone of the New Testament is to encourage prayers for good health and healing, which are regarded as symbolic anticipations of the final coming of God's Kingdom.[2]

Social Aspects

Fourthly, it needs to be noted that there are inherently social aspects to the healing practice of Jesus. What I refer to here is not just the inclusivity of his ministry, but also the reality that, for poor people in particular, illness could involve the stigma of being 'unclean' in a way that cut them off from the worshipping community. We are told that there were as many as 248 commands and 365 prohibitions making up the Law, many of them to do dietary matters and hygiene.[3]

Apart from the fact that knowledge of the Law became the prerogative of scholars and the Establishment, the poor, as always, were more likely to suffer from illness. And so, when Jesus cures a leper, for example, or casts out an 'evil spirit', one needs to reckon with the fact that what is involved here is not merely a personal matter but also the re-integration of that person in the community. Leprosy, in particular, is often a 'catch-all' title for various skin diseases, often due to poor diet and hygiene, which resulted in automatic expulsion 'outside the camp' – precisely where Jesus himself ended up at his crucifixion, such was his identification with the poor and sick.

Discipleship of Healing

There is, fifthly, the way in which the healing practice of Jesus ought to be understood today. While living in Northern Ireland in the 1980s, I attended many Protestant Pentecostal and Evangelical services which often included a healing dimension: one was encouraged to believe that if one had faith, one would be healed. On the Catholic side, there has been a resurgence of interest in this kind of healing service through the Charismatic Renewal movement, while there has been a more constant belief in the power of healing associated with holy places such as Lourdes and Knock, not to mention the intercession of saints and holy people like Padre Pio and John Sullivan. And why not – after all, did not Jesus give this mission to his disciples, did

he not say, in sending them out to the whole world, that 'they will lay their hands on the sick, who will recover' (Mk. 16: 18)?

There are two dangers in any simplistic reading of this understanding of what discipleship might involve. One concerns the so-called Prosperity Gospel approach, popular in parts of the United States in particular but often exported more widely. This approach teaches that if you have faith – if you *really* have faith – then life will be good, you will make money, and you will have good health. Well, apart from this being a mis-reading of the sense of the Bible taken as a whole (neither money nor health is the ultimate criterion of the good life) it also can be psychologically very damaging – think, for example, of the seriously ill person who does not experience healing after prayer, and who now may feel the burden of guilt and depression at his or her presumed lack of faith, or may doubt in the very existence of the God who could comfort at a time of suffering.

The other danger is that this approach ignores, or undervalues, the principal way in which God works in our world through us. St Irenaeus liked to speak of Jesus Christ and the Holy Spirit as the two hands of God the Father. Carrying on this theme of instrumental causality, St Ambrose spoke of every worker being 'the hand of Christ'. In other words, the principal way in which God is present in our world, in which his Kingdom comes, is through the conscientious, competent, inventive work of us human beings. And so there is the human desire to help the sick, the medical skill that is required, the social and bureaucratic policy and organisation that can make those desires and skills as universally available as possible – this is at the heart of Christian discipleship of the healing Jesus in our world of today, a mission we gladly share with those of all other and no faiths.

None of this ought to be taken as denying the rightful place (and the power) of prayer, or of the turn to holy places and people for help. The Catholic Church, in particular, has made a Sacrament of this 'turn to God' for help, the Sacrament of the Anointing of the Sick (still, it seems, too closely associated only with the kind of sickness which is close to death, and so still in practice often conjuring up the older title of the Sacrament of Extreme Unction). We are talking about 'both/and', not 'either/or' – as applies, indeed, across a whole range of related topics which are often reduced to alternatives of separation rather than distinctions of relationship (for example, religion–science; religion–politics, and so on).

This more inclusive approach makes intellectual sense because ultimately all is 'in God's hands', God is working through the skilled individuals and systems that are the professional healers of today. There is also a great deal that these professionals don't know, strange things happen (as is evidenced, for example, in the old tradition of faith-healers), and the believing Christian will have faith not just in the God-inspired professionals but in the mysterious irruptions of the Kingdom into our 'now' that accompanied the ministry of Jesus and that can, as St Ignatius put it in a different context, occur today as instances of 'consolation without cause'.

Vision and Values

From this consideration of the healing practice of Jesus, to which we might add his other prescriptions regarding a moderate lifestyle, we may extrapolate a notion of the person and society in which health of mind and body – a holistic model of health care, in today's jargon – is intrinsic to the Christian vision. In an earlier study, the Jesuit Centre for Faith and Justice along with the Adelaide Hospital Society outlined four principal values which we argued ought to accompany this vision: care, excellence, justice and freedom.[4] It remains to comment briefly on some pertinent implications of the social implementation of this vision and these values.

Social Implications

The principal source of the nuanced application of the teaching of Jesus to the social arena is to be found in our day in Christian social ethics, and for Catholics in Catholic Social Teaching. I limit myself to two observations taken from this corpus of teaching.

First, with reference to the question of introducing a system of universal health insurance, as raised earlier in this issue of *Working Notes*, the attitude of Catholic Social Teaching to the free market is worth recalling.[5] On the one hand, the teaching is appreciative of the positive value of the free market:

It would appear that, on the level of individual nations and of international relations, the free market is the most efficient instrument for utilizing

resources and effectively responding to needs. However, the teaching is also acutely aware of the limits of the market:

But this is true only for those needs which are 'solvent', insofar as they are endowed with purchasing power, and for those resources which are 'marketable', insofar as they are capable of obtaining a satisfactory price. (Centesimus Annus, n. 34*)*

The market, then, is never sacrosanct, but rather:

It is a strict duty of justice and truth not to allow fundamental human needs to remain unsatisfied, and not to allow those burdened by such needs to perish. (Centesimus Annus, n. 34)

And so, useful though the market is, 'there are important human needs which escape its logic', and an 'idolatry' of the market 'ignores the existence of goods which by their nature are not and cannot be mere commodities' (*Centesimus Annus*, n. 40).

Our two-tier health system in Ireland is a scandal; it offends against justice ... and it requires radical reform.

One needs to avoid a fundamentalism in applying Catholic Social Teaching, just as one needs to avoid a biblical fundamentalism. And so the application of this teaching concerning the value and limits of the free market to the issue of health care in any particular context needs, as always, to be guided by prudent political judgements and not some *a priori*, however sacred in source, ideology. However, given what we know about the workings of the free market in our world today, given in particular the experience of the United States of America (following a free market approach) with the highest expenditure per capita in the world for health care and the worst outcomes of all developed countries, then it really does behove us in this country to ask whether indeed it is better to be closer to 'Boston rather than Berlin'. Our two-tier health system in Ireland is a scandal; it offends against justice and the socially inclusive practice of Jesus Christ, and it requires radical reform.

Secondly, with the increasing professionalisation of health care, its tendency to be seen nowadays as a job rather than as a vocation, there is real need for the value of care to be understood as going beyond technical expertise. When people are sick, 'they may be vulnerable, dependent, needy, and issues of intimacy and trust come to the fore'.[6] In this context, it is wise for civil authorities to attempt to integrate this aspect of care into professional training, but also to allow, and indeed where necessary (one thinks of chaplaincy services) subsidise, the more explicitly vocational approaches of voluntary and religious groups which address this real need.

Conclusion

There are many positive realities in the Irish health service, not least the competence and dedication of those working within it, and there have been real improvements too – one thinks, for example, of what is happening in the provision of more reliable cancer diagnosis and treatment. However, a Christian perspective would also identify severe shortcomings, which include the basic model employed which, with over-reliance on the free market, perpetuates the private–public divide, widening and deepening the two-tier nature of the service. And, in the holistic context that this Christian perspective offers, it is also appropriate to ask questions about the level of provision of social care and support services and our society's commitment to addressing the income inequality and lifestyle factors which endanger public health.

Notes

1. Gabriel Daly O.S.A., *Creation and Redemption*, Dublin: Gill and Macmillan, 1988, p. 161.
2. Dermot Lane, *Christ at the Centre*, Dublin: Veritas, 1990, pp. 30–31.
3. Gerald O'Collins, *Interpreting Jesus*, London: Chapman, 1983, p. 51.
4. The Adelaide Hospital Society and the Jesuit Centre for Faith and Justice, *The Irish Health Service: Vision, Values, Reality*, Dublin: 2007.
5. For what follows, see Pope John Paul II, *Centesimus Annus (On the Hundredth Anniversary of Rerum Novarum)*, Encyclical Letter, 1 May 1991.
6. The Adelaide Hospital Society and the Jesuit Centre for Faithand Justice, *op. cit*., p. 3.

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Universal Health Insurance
What is it and would it be effective in Ireland?

Fergus O'Ferrall

Introduction

The Irish health care system is failing to meet the needs and expectations of Irish people in so many different areas where care ought to be provided.[1] Dominating a range of failures in the system is the fact that care is provided in an inequitable manner. This is despite the stated commitment of the 2001 Health Strategy, *Quality and Fairness*, and of its 1994 predecessor, *Shaping a Healthier Future*, that 'equity' would be one of the core values underpinning Irish health care.[2]

The most striking examples of lack of equity in the system occur in hospital care: in effect, people on higher incomes are treated in preference to poorer people in a system where capacity is not adequate to care for everyone at the point of need. In addition, the quality of service given to those who can afford to use private care is superior to that given to those who cannot afford it – in terms of speed of access, consultant care and accommodation.

Issues of equity arise also in relation to primary care. While those on the lowest incomes qualify for a medical card, and those a little better-off may be eligible for the doctor-only medical card, many individuals and families with incomes that are limited but just above the cut-off point for eligibility find themselves facing what are now significant levels of GP fees and prescription charges. It is families with children, and individuals and families experiencing chronic or recurring illness, who are most seriously affected by the lack of access to GP care free at the point of use.

Furthermore, there is an unequal distribution of GP services, with many poorer communities – the very communities most likely to have poorer health – lacking or having only limited availability of GP services. We have, in short, a 'two-tier' health system which does not treat every citizen fairly.

The question arises whether there is a better way to finance our health care so that every person will be treated fairly and will receive the care he or she needs. In particular, would universal or social health insurance be fairer and more effective than our present financing arrangements?

How is Health Care Funded at Present?

Currently in Ireland, we pay for the health system in three ways. The first is through taxation, including a health levy. (In the Supplementary Budget of April 2009 it was announced that this levy would rise from the existing 2 per cent of income, or 2.5 per cent in the case of higher incomes, to 4 per cent, with a higher rate of 5 per cent.[3]) The second is through out-of-pocket payments – for example, fees paid to GPs by those who do not have a medical card; fees paid to consultants in private practice by patients not covered by health insurance; fees to physiotherapists, dentists and opticians; charges for prescribed medicines. And the third is through supplementary private health insurance.[4]

The proportion of the population covered by this supplemental private insurance has increased significantly over the past twenty years – coverage rose from just over 30 per cent in 1989 to 40 per cent in 1999 and it now stands at around 50 per cent.[5] The increase of the past two decades reflects not just the growth in disposable income that occurred over the period but an increasing perception that without such coverage people would experience long delays in accessing hospital services and would receive inferior care.

It is the unique mix of public and private financing and provision which creates the 'two-tier' system of health care in Ireland. In fact, however, taxation accounts for about 75 per cent of total health care expenditure. Out-of-pocket payments account for 15 per cent and just 10 per cent is contributed by supplemental private health insurance.

Thus all Irish citizens publicly fund a system which then allows a relatively small percentage of private insurance funding to grossly distort the delivery of care in favour of those who can afford such insurance: truly a case of the 'tail wags the dog'. The current system 'rations' the care

provided, leading to the situation where we have long waiting lists for public hospital services, patients lying on trolleys in Accident and Emergency Departments while awaiting admission to a hospital ward, and instances of gross lack of care for those who need it.

The Irish health care system is very poor at relating performance and outcomes to the financial allocations provided: under the existing system, public facilities receive a fixed financial allocation in advance and have to 'ration' care to stay within their budget. The result is that they can find it more cost effective *not* to treat patients; in other words, there is no financial drawback to keeping people on a waiting list. Such a system is not efficient or effective.

What is Universal Health Insurance?

Universal health insurance is a means of paying for health care which has been adopted by many Western and Central European countries. It has its origins in a system of limited public health insurance introduced in Germany in the late nineteenth century. (The terms 'universal health insurance' and 'social health insurance' are often used interchangeably; I am using the former because it is the term which has tended to be used in the emerging debate in Ireland on this issue.)

Under a universal health insurance system, payment is made through mandatory (compulsory) or universal insurance premia (fees). It is essential to understand the difference between *social* (or universal) health insurance and *private* health insurance. Social health insurance is based upon the concept of social solidarity: it involves *all* citizens being covered and having equal access to care and treatment – to a common 'basket' or set of health services – for equal need, *and* all contributing to cover (insure) the risks of all people in respect of their health care needs. Private health insurance, in contrast, is an individual payment made to cover the risk of an individual and his or her dependants needing health care; by definition, it excludes those who have not been able to purchase it.

Features of UHI

There are many versions of universal health insurance (hereinafter referred to as UHI) in operation: the level of contributions and the range of services under UHI schemes vary from country to country. What is outlined here is a 'model' UHI system, the underlying principles of which are the provision of health care on the basis of need and the funding of care on the basis of ability to pay.

The following are key features of this model or 'ideal type' UHI system:

- All citizens are insured through the payment of premia to a social health fund (or funds); such contributions are based on income, not on the cost of services individuals are likely to use, and so factors such as age or pre-existing illness or disability do not influence the level of payment.
- Contributors pay such premia instead of the portion of taxation previously required to fund health services, and the revenue generated is kept *separate* from the Exchequer or State funds raised through taxation.
- The State pays or supplements the premia of those on lower incomes (for example, the medical card population in the Republic) and so every citizen is an insured patient with equal access to the health system.
- The health insurance fund (or funds) is used to finance care for insured persons.
- Care covered by the health insurance fund(s) may be delivered by public, private not-for-profit, or private for-profit health care providers.
- Access to treatment and care is determined by clinical need rather than ability to pay.
- Health care is free at the point of need.
- 'The money follows the patient' – in other words, the amount of revenue generated by hospitals and primary care centres is determined by the number of patients provided with treatment and care. Health care providers, whether public, private or not-for-profit, therefore have a strong incentive to care for as many people as possible as effectively as possible. This is in contrast to a system where allocations are 'fixed' for a set period and are then rationed.

The Advantages of UHI

There are five main advantages to UHI:

- It enables the provision of a one-tier system of hospital care, with access and treatment based on medical need, not income;
- It provides a way to deliver GP services free of charge at the point of usage for the entire population;
- It puts the patient 'first and centre';
- It is more transparent – citizens see what they are getting for their premia;
- It combines the promotion of social solidarity with more accountable and efficient public service provision.

It would be a very significant step forward for Ireland to develop a health system where each citizen is treated fairly with no financial discrimination. It would greatly help the reform of our public services if providers in the public sector were given a strong incentive to make the delivery of quality health services to citizens their top priority – a failure to do so would mean they would face losing their share of service provision, and of the accompanying revenue, as citizens sought to be cared for by providers in the private not-for-profit or for-profit sectors.

In UHI, the inevitable 'ups and downs' of the State's annual revenue collection and expenditure allocation processes are not relevant – the health fund(s) would be *separate* and citizens could see continuity in health funding and a direct link between the premia they were paying and the level of services provided. This transparency has the potential to generate greater public commitment to providing an adequate level of financing for health services and greater interest in ensuring efficiency in the use of resources.

UHI would help reform public services by combining social solidarity with another key democratic concept – 'subsidiarity'. Our current health system is excessively centralised. A UHI system by its nature facilitates the realisation of subsidiarity: more responsibility and capability are given directly to the actual providers of health care – hospitals and primary care centres, for example.

A Mechanism not a Policy

The authors of two detailed studies commissioned by the Adelaide Hospital Society to examine the feasibility of UHI in an Irish context strongly emphasise that UHI is a mechanism, not a policy: '[UHI] is a mechanism to achieve a policy and not a policy in itself'.[6] They note further: '... the design of a [UHI] scheme is, or should be, dependent on the objectives to be achieved in the health system, such as value for money or fairness.'[7]

- Are you VHI? Aviva? Quinn Health Care?
- No, I'm just sick *© F. McGrath*

In the Irish context, much of the discussion about UHI has centred on its potential to bring about greater equity within health care, which is understandable given the lack of fairness that so clearly characterises the current system. A study by Samantha Smith, *Equity in Health Care: A View from the Irish Health Care System* (published in April 2009), highlights the challenge of defining what is equity in health care, given the diversity of political philosophies propounded in Western societies.[8] The study points out that the definitions of equity in Ireland's current Health Strategy embody a number of different and sometimes conflicting principles. In general, however, these definitions lean towards egalitarianism. Yet, the reality is that in many respects it is libertarian rather than egalitarian principles that apply in practice in the funding and delivery structures of our health service.[9]

The consequence of the lack of clarity and consistency regarding the definition of equity in Irish health care is the presence of contradictory, ineffective and inequitable features throughout the system. The development of an explicit and coherent statement of equity would obviously be an essential 'first step' in devising a UHI scheme that aimed to be equitable as well as efficient in its financing and delivery arrangements.

Potential Problems

UHI is clearly not some kind of easy or instant solution to the problems of a country's health service. The appropriate design and cost-efficient management of a UHI system is crucial. If, for example, the contribution base for the scheme is too narrow, so that revenue generated is insufficient, it may result in government having to provide subsidies from general taxation and/or in the range of services made available being limited and co-payments for services being imposed. Confidence in and support for the system then suffers, resulting in the emergence of a separate set of services affordable only to those on higher incomes, and so a two-tier system is once more in place.

The introduction of UHI can be expected to lead to an increase in demand for health care. While this may include some inappropriate use of services, it is also the case that it will mean a health system now responding to real needs that previously went unmet because individuals could not afford to access care. There is, for example, evidence that in Ireland some people delay or do not seek primary care because of cost factors.[10] The outcome may be delayed diagnosis and in some instances serious consequences for patients and additional long-term demands on the health service.

It is vital that the capacity problems in our health system are rectified, whether or not we introduce UHI

In the case of Ireland, the question of increased demand following on the introduction of a system of UHI brings to the fore the need to address the long-standing capacity problems of our health system.

The capacity issue relates, firstly, to a shortage of GPs – we need more primary care doctors and we need them especially if we are to have primary care free to all at the point of need.[11] Capacity problems arise also in relation to hospital services – comparisons with other OECD countries show that Ireland needs more acute hospital beds and a greater number of hospital doctors.[12] We also require more long-term care facilities, rehabilitative services and community health facilities.

It is vital that the capacity problems in our health system are rectified, *whether or not we introduce UHI*. Regardless of the funding mechanism(s) adopted, there is a need to invest in our future health care system in order to meet the needs of our population. One of the studies carried out for the Adelaide Hospital Society showed that the costs associated specifically with the additional capacity requirements arising from UHI would account for around a quarter of the overall amount that should be invested to meet current and future capacity needs up to 2020.[13]

In a Time of Crisis is UHI Possible in Ireland?

Professor Tom Keane, who brought his Canadian experience to Ireland as Interim Director of the HSE National Cancer Control Programme, has stated: 'All the change in Canada was because of recessions' (*The Irish Times*, 14 February 2009). Now, more than ever, we need a fairer, more efficient and effective health service. Now is the time to reform our health financing arrangements whereby we ensure we get value for money and provide proper health care.

The two studies commissioned by the Adelaide Hospital Society to examine the requirements and costings of UHI in the context of Ireland's health care needs showed that, properly designed and planned, a UHI system could provide:

- Free GP care for all;
- Equal hospital treatment based upon clinical need for every citizen;
- More effective and efficient health care providers.

How Much Will UHI Cost?

The percentage of income or wealth which needs to be paid by or for each citizen in a UHI system obviously depends upon the size of the common 'basket' of services which are fully covered by the insurance. The analysis commissioned by the Adelaide Hospital Society estimated that a fully comprehensive health service for all would involve health spending as a proportion of GDP rising from 7.5 to 8.9 per cent or an increase of €2.1 billion in running costs at 2006 prices. This

would still be comparatively low in European Union terms.

Significant steps towards the ultimate objective of a comprehensive UHI system could be taken for comparatively little additional spending. For example, we could provide:

- Full medical cards to all children and young people up to the age of nineteen at an additional cost of just €160 million per annum (2006 prices);

- Full medical cards for *all* the population would cost a net €217 million extra on top of the €2.1 billion spent on primary care by the State and the €692 million which citizens now spend in the form of out-of-pocket payments.

Obviously, the economic downturn affects the costings and feasibility of introducing a UHI system, but a core argument in favour of a change in this direction is that no matter what the total health care expenditure amounts to it can be more fairly and effectively used in a UHI system.

Conclusion

History shows that radical health care reform happens in a time of crisis and challenge. The NHS was introduced in the UK after the Second World War. The USA is planning major health reform now in a time of global recession. Eastern European countries after the fall of Communism developed universal health care when relatively poor circumstances prevailed.

As we approach the time when we will celebrate one hundred years of the independence gained in 1921, we in the Republic of Ireland might set ourselves the exciting and challenging goal of putting in place a system of universal and equitable health care.[14] We have the advantage of being able to take account of experiences elsewhere – of countries which have long had a universal health insurance system and of those which have adopted one relatively recently – so that we could 'avoid rather than imitate harmful features that have found their way into the [UHI] systems of other countries'.[15]

Strong and courageous leadership is required if Ireland is to develop a pathway to universal health care. I am confident that the people would respond and be inspired by the grand democratic goal of equal care for all citizens free at the point of need. Imagine an Ireland where the financial burden of illness was shared by all and where all would be assured of access to services on the basis of need, not income.

Notes

1. See A. Dale Tussing and Maev-Ann Wren, *How Ireland Cares: The Case for Health Care Reform,* Dublin: New Island, 2006, for a comprehensive analysis of the issues and problems in the Irish health care system.
2. Department of Health, *Shaping a Healthier Future: A Strategy for Effective Health Care in the 1990s,* Dublin: Stationery Office, 1994; Department of Health and Children, *Quality and Fairness: A Health System for You – Health Strategy,* Dublin: Stationery Office, 2001.
3. The entry level for the lower rate of the health levy (now 4 per cent) is €26,000 per annum; the threshold for the higher rate of 5 per cent was lowered from the previous level of €100,100 to the new level of €75,036 per annum in the April 2009 Supplementary Budget.
4. The funding of Irish health care is analysed in two reports published by the Adelaide Hospital Society: *Social Health Insurance: Options for Ireland* (2006) and *Social Health Insurance: Further Options for Ireland* (2008). Both reports were written by Stephen Thomas, Charles Normand and Samantha Smith. See: www.adelaide.ie
5. Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Options for Ireland*, Dublin: Adelaide Hospital Society, 2006, p. 13.
6. *Ibid*., p. 9.
7. Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Further Options for Ireland*, Dublin: Adelaide Hospital Society, 2008, p. 5.
8. Samantha Smith, *Equity in Health Care: A View from the Irish Health Care System*, Dublin: Adelaide Hospital Society, 2009 (An Adelaide Health Policy Brief), pp. 2–4.
9 *Ibid*., p. 5–6.
10. Anne Nolan and Brian Nolan, 'The Utilisation of GP Services', in Brian Nolan *et al* (eds.), *The Provision and Use of Health Services, Health Inequalities and Health and Social Gain,* Dublin: Economic and Social Research Institute, 2007; Dermot O'Reilly *et al*, 'Consultation Charges in Ireland Deter a Large Proportion of Patients from Seeing the GP: Results of a Cross-Sectional Survey', *The European Journal of General Practice,* Vol. 13, Issue 4, 2007, pp. 231–36.
11. The capacity problems are analysed in detail in Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Further Options for Ireland* (2008) and in a number of other published studies.
12. *Ibid*., pp. 20–27.
13. *Ibid*., p. 28.
14. See the joint policy paper of the Adelaide Hospital Society and the Jesuit Centre for Faith and Justice for a fresh articulation of the vision and values required: 'A health system which is centred upon the dignity of every human being, which treats body, mind and spirit in a holistic way, and which treats each person upon the basis of their need rather than their financial status.' (Adelaide Hospital Society and the Jesuit Centre for Faith and Justice, *The Irish Health Service: Vision, Values, Reality*, Dublin, June 2007; www.adelaide.ie and www.jcfj.ie)
15. Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Options for Ireland* (2006), p. 5.

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Alcohol: A Key Public Health Issue

Margaret Burns

Introduction

The television documentary, *When the Party's Over*, presented by Dr Mark Hamilton and broadcast on RTE just before Christmas 2008, provided many memorable images of Ireland's current drinking habits and of the consequent impact on individuals and society as a whole.

One of the most striking features of the programme was the way it so clearly illustrated the fact that 'ordinary social drinking' as it has come to be defined in modern Ireland makes for levels of consumption that are well in excess of the limits for low-risk drinking advised by health authorities. It would appear that many people in Ireland would find themselves readily agreeing with the view of the young woman, quoted in a 2003 article in *The Observer*, who said: 'That is not binge drinking. That's called having a social life.'[1]

Consumption Patterns

Anecdotal evidence of excessive alcohol consumption is consistently confirmed by surveys on drinking in Ireland. The survey results, in the case of both teenagers and adults, reveal levels of consumption that are high in themselves and high in comparison to other countries. Media and public attention tends to focus on the findings regarding under-age drinking. However, findings on adults' drinking habits are also a cause for public health concern, not only because of the levels and patterns revealed, but because adults' drinking plays a crucial role in shaping children's attitudes regarding what is 'normal' in terms of alcohol consumption.

A Eurobarometer study covering twenty-nine countries, which was carried out in October/November 2006 and published in 2007, is just one of several surveys in recent years on the alcohol consumption patterns of adults in Ireland. In this study, Ireland emerged as the country with the highest incidence of binge drinkers, while having the lowest incidence of daily drinkers. The findings showed that a third of Irish people 'usually' consumed at least five drinks on any occasion they drank: this was higher than in any other country in the survey, and was significantly higher than the figure for the (then twenty-five member) EU as a whole, which was just 10 per cent. Of the Irish respondents, 54 per cent consumed five drinks or more at least once a week; the overall EU figure was 28 per cent.[2]

Underage Drinking

The ESPAD (European School Survey Project on Alcohol and Other Drugs) surveys, which have been conducted at four-yearly intervals since 1995, have consistently revealed a high incidence of under-age drinking and drunkenness in Ireland. The most recent, in 2007, showed that 86 per cent of the Irish sample population (i.e., students who would reach their sixteenth birthday in the year the data was collected) had at some point in their lives consumed alcohol and 78 per cent had done so during the previous twelve months.[3]

Nearly half (47 per cent) the Irish students said they had been drunk during the previous twelve months; 26 per cent reported being drunk in the previous month, compared to a European average of 18 per cent. This figure meant that Ireland ranked sixth highest among the thirty-five countries in the study in the incidence of students being drunk.[4] More girls than boys (44 per cent as against 42 per cent) reported heavy drinking during the previous month.

Overall Consumption

Aside from the data from surveys which look at patterns of drinking, evidence of potentially harmful drinking is implicit in the figures for overall consumption of alcohol in Ireland.

The drinks industry frequently draws attention to the fact that total consumption of alcohol has been falling since 2001. In that year, consumption peaked at a (per annum) figure of 14.3 litres of pure alcohol per person over fifteen years of age. By 2008, consumption had fallen to around 12.4 litres per capita. What the drinks industry does not highlight is that between 1987 and the peak in 2001, consumption had increased by 46 per cent. Even at current levels, we are still drinking more than 20 per cent above the level of twenty years

ago and Ireland has one of the highest adult consumption rates in the EU.

The level of consumption in 2008 is the equivalent of 490 pints, or 129 bottles of wine, or 46 bottles of vodka per person over a year. In terms of weekly consumption, the overall figure for 2008 would translate into around 20 standard drinks consumed per person per week. (The limits for low-risk drinking are 14 standard drinks for women and 21 standard drinks for men, spread out over the week.[5]) Since around 20 per cent of the population does not drink alcohol at all, and many people drink very moderately, the actual figure for the per capita consumption of those who drink more heavily is inevitably very high indeed.

Harm

The WHO has identified alcohol as the third highest risk factor (after tobacco and high blood pressure) for premature death and ill health in developed countries. Alcohol is associated with a wide range of diseases and conditions, including cirrhosis of the liver, a number of different cancers, heart disease, and stroke. Alcohol consumption can lead to dependence and addiction. It can lead also to accidents in the home, the workplace and on the streets and roads, as well as to fights and assaults. The resultant injuries may range from being minor to being so serious that they cause long-term disability or death.

There is emerging evidence of the harm which alcohol may do to the developing brain during adolescence, potentially resulting in damage to the area of the brain involved in learning and to the area involved in self-regulation, judgement and impulse control. Harmful alcohol consumption may also affect health in the wider sense of general wellbeing by, for example, damaging individuals' financial security, relationships, and ability to avail of educational and employment opportunities.

In addition to the impact which alcohol may have on the life of the individual drinker, there is also what Sir Liam Donaldson, Chief Medical Officer for England and Wales, has called the 'collateral damage of alcohol' – the harmful effects on other individuals and on society as a whole.[6] Such damage includes injuries and death as a result of road accidents, assaults and fights, and emotional and financial damage to marriage and other relationships. The harmful consumption of alcohol by parents and carers can have an extremely negative effect on children in terms of financial and emotional insecurity and it may even be a factor in abuse and neglect.

Data for Ireland on mortality and morbidity reveal a rising scale of health-related damage from alcohol. For example, between 1995 and 2004, there were 1,775 alcohol-related deaths in Ireland; the incidence of such deaths per 100,000 of the population aged over fifteen increased from 3.8 to 7.1 in this period. It is generally accepted that these figures are an underestimation of the true extent of alcohol related mortality.

Hospital admission figures show that large numbers of patients are treated for alcohol-related injuries and illness on both an outpatient and inpatient basis. The findings of a national study, covering six major acute hospitals, which profiled attendances at accident and emergency departments over a week, showed that more than a quarter (28 per cent) of attendances because of an injury were alcohol-related. Half these patients were in the 18–29 age group and three-quarters were male. Between 1995 and 2004, the numbers of admissions for inpatient treatment of alcohol-related conditions almost doubled, from over 9,000 to over 17,000.[7]

Alcohol-related disorders constitute one of the most common reasons for admission to inpatient psychiatric care. Less readily quantifiable but no less real are the complex social and psychological alcohol-related harms to drinkers and their families that result in additional demands on social work, psychological and family support services.

In sum, harmful alcohol consumption in Ireland causes immeasurable damage to the health and wellbeing of individual drinkers and of many others who are affected in varying ways and to varying degrees. It also places significant additional demands on an overstretched health service and an underdeveloped social support system.

Policy

In the face of the mounting evidence regarding alcohol-related damage to health and well-being, and of the reality of significant additional demands being placed on health and other services as a consequence, the policy responses in Ireland over the past two decades have been seriously

inadequate and often contradictory. Weak public health measures have been overshadowed by other measures that have made alcohol cheaper and more easily available.

A National Alcohol Policy was published in 1996 and set out an overall public health approach to dealing comprehensively with alcohol issues.[8] However, the specific legislative changes, policies and structures that should have followed did not materialise. Likewise, there was no active, co-ordinated, government response to the recommendations of the Strategic Task Force on Alcohol in 2004[9] and no plan or mechanism for the progressive implementation of these recommendations was put in place.

The introduction of randomised breath testing in July 2006 stands out as a rare example of significant policy reform**.** However, Ireland still retains a drink driving limit that is higher than that in the great majority of EU countries. The National Road Safety Authority has recommended a reduction of the limit to 50 mgs of alcohol per 100 mls of blood, with a lower limit of 20 mg for learner and professional drivers.

Three Key Areas

Internationally, three policy areas are recognised as being essential to an effective public health approach to preventing alcohol-related harm: these are pricing, availability and marketing. In Ireland, policy in respect of all three has been weak and ineffectual.

Pricing

Prior to every Budget, media commentators speculate on the likelihood of additional taxes being imposed on 'the old reliables', which are assumed to include alcohol. The reality is, however, that until the increase in excise duty on wine in the October 2008 Budget, alcohol taxes had not increased since 2002. In that year, the duty on spirits (and in particular alcopops) was increased – and a notable drop in consumption followed. In 2001, the duty on cider was raised but that on beer has not increased since 1994.

In reality, then, there have been just three increases in duty in fifteen years. Even in the depth of the current crisis in the public finances, when raising additional revenue has become a priority, no increases in alcohol duties were imposed in the Supplementary Budget of April 2009.

It is true, as the drinks industry frequently points out, that alcohol taxes in Ireland are higher than in many European countries. Overall, however, alcohol has become significantly more affordable in Ireland since the mid-1990s. A recently published survey on the 'affordability' of alcohol in twenty EU countries shows Ireland to be one of eight where alcohol became at least 50 per cent more affordable over the period 1996 to 2004.[10]

Off-licence sales of alcohol have increased dramatically
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The greater affordability of alcohol is, to a large extent, attributable to the steep rise in incomes in the decade from the mid-1990s onwards. Disposable incomes are now falling but the effect of the other key factor in affordability – the sharp decline in the cost of alcohol sold for 'off-premises' consumption – still prevails. The abolition in 2006 of the Groceries Order (which had prohibited the below-cost selling of products, including alcohol) opened the way for the undercutting of competitors' prices and for supermarkets and other stores to use promotions of very cheap alcohol as a way of attracting customers. The result is the widespread availability of alcohol at a price less than that for bottled water.

Section 16 of the Intoxicating Liquor Act 2008 provided that the Minister for Justice, Equality and Law Reform could introduce regulations to prohibit or restrict retail outlets advertising or selling alcohol at reduced prices. However, no such regulation has yet been introduced.

(It might be noted that in February 2009 the Scottish Government stated its intention to introduce statutory regulations to control low-cost selling of alcohol, including setting a minimum price for a unit of alcohol.[11] And in March 2009, the Chief Medical Officer for England and Wales,

Sir Liam Donaldson, called for the setting of minimum pricing, suggesting a figure of 50 pence per unit of alcohol.[12])

Availability

As a result of the Intoxicating Liquor Act 2008, there has been a reduction in the hours during which alcohol can be sold in off-licences and 'mixed trading premises' (supermarkets, convenience stores, garage forecourts, for example).

Scope for some further restriction on the availability of alcohol was provided by Section 9 of the Act. This allowed the Minister for Justice, Equality and Law Reform to introduce regulations that would require mixed trading stores to structurally separate the location of alcohol, so that it would be sold only in a specific section of the shop, which would be separated by a wall or similar barrier and accessible by a gate or door.

However, as a result of lobbying by the drinks industry, the commencing of Section 9 has been put on hold. In mid-May 2009, there was the formal launch of a voluntary Code of Practice which had been agreed between the Department of Justice, Equality and Law Reform, the Department of Health and Children and representatives of ten of the major retailers operating in Ireland. The retailers involved have created a new body, Responsible Retailers of Alcohol in Ireland (RRAI), which will communicate and monitor the implementation of the Code and establish a customer complaints procedure.

Alcohol is now not only a great deal cheaper but is far more readily available than it was just a decade ago

The provisions of the Code in terms of the physical separation of alcohol in supermarkets and other stores are much weaker than those envisaged in the legislation. Furthermore, not only is the Code voluntary, but its monitoring, while claimed to be independent, will 'be under the auspices of the RRAI'.[13] And the reality is that as much as 20 per cent of alcohol sales for off-premises consumption is by retailers *not* involved in the RRAI. All this serves to indicate a significant retreat from the provisions of the 2008 legislation.[14]

Even if statutory regulation as provided for in the 2008 Act had been brought into effect, it would still have represented only a very minor rolling back of the process of liberalisation of availability that characterised the previous decade. This resulted in a vast increase in the number and range of outlets for the off-licence sale of alcohol. For example, the number of off-licences and of 'mixed trading' premises authorised to sell the full range of alcohol products increased by almost 70 per cent between 2001 and 2007; there was a significant increase also in the number of premises authorised to sell wine only.[15] Alcohol is now, therefore, not only a great deal cheaper but far more readily available than it was just a decade ago.

Marketing

A comprehensive review (published in January 2009) of the findings of longitudinal studies on the impact of alcohol advertising and promotion on young people underlines why marketing is considered to be such a key area of alcohol policy. The review, by an international group of alcohol experts, found 'consistent evidence' that:

exposure to alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol and to drink more if they are already using alcohol.[16]

Given the high levels of consumption of alcohol by Irish teenagers and the very young age at which many of them begin to drink, the extent to which they are exposed to alcohol advertising clearly ought to be cause for serious concern and strong policy reaction. In fact, however, this is yet another area where 'light touch' regulation rather than forceful legislation has been adopted.

Draft legislation providing for the control (though not the banning) of alcohol advertising was abandoned by the Government in 2005[17]and substituted by voluntary guidelines agreed by the alcohol and advertising industries and the Department of Health and Children. In August 2008, revised and somewhat strengthened *Codes of Practice to Control Alcohol Marketing, Communications and Sponsorship* were published. And the new Code of Practice of the RRAI, referred to earlier, also contains some stipulations regarding advertising.

The fundamental weakness of the approach that has been adopted in Ireland to controlling alcohol advertising is that it is voluntary, largely self-regulated, and without any real penalties attaching to infringements.

An underlying assumption of the voluntary codes is that the restrictions imposed will reduce the likelihood that advertisements for alcohol will be targeted at children. However, research has shown that advertisements do not have to be specifically targeted in their content or in where they are placed in order for them to be seen by and have an influence on children and teenagers.[18]

Another assumption is that restrictions on when and where advertisements may be placed will result in a lowering of the numbers of children and young people exposed to alcohol advertising. This, in effect, implies that it is acceptable that tens of thousands will see, and be influenced by, alcohol promotional material, just as long as the number does not exceed a certain percentage. Such an approach is completely at variance with the UN Convention on the Rights of the Child, to which Ireland is a signatory, which provides that *every* child under eighteen has an equal right to have his or her health protected from harm.

In September 2008, the Irish College of Psychiatrists called for a complete ban on alcohol advertising, arguing in particular that the high incidence of drinking among young people, and the seriousness of the potential harm to them, warranted this level of response.[19] The Government has in the past argued that a ban on alcohol would be contrary to EU law in regard to the free movement of goods and services.[20] However, the European Court of Justice has upheld the right of the French Government to pursue a very restrictive approach to alcohol advertising.[21]

Why Such Permissive Policies?

The very pervasiveness of a culture of heavy drinking in Ireland may, paradoxically, serve to lessen rather than strengthen the willingness of government to take decisive action in terms of putting in place effective policies and implementation structures.

With regard to the public, the concern that does exist has not been of sufficient 'volume' to translate into concerted, forceful demand for change. The findings of a public opinion survey commissioned by the HSE in early 2008 give an insight into public attitudes that do nothing to challenge the present inadequate policy response to alcohol problems. Over 90 per cent of the adults questioned acknowledged that teenage drinking was a problem, but only 50 per cent thought they could do something to stop teenagers obtaining alcohol. Even more revealing was the finding that only 15 per cent thought that their own drinking habits influenced young people around them, and just 40 per cent said they would be willing to make changes in these habits in order to pass on a message of responsible drinking to the younger generation.[22]

With regard to politicians, it can be expected that some will share the widespread permissive attitude towards the typical, but dangerous, pattern of Irish social drinking; other politicians may be concerned about the level and patterns of alcohol consumption but fear that calling for the type of measures which are known to be more effective will not be popular with many sections of the public. However, it is important to note that TDs and Senators who have been part of Joint Oireachtas Committees which have examined aspects of the alcohol issue have been prepared to sign up to strong recommendations regarding the development of policy.[23]

Partnership Approach

Irish governments for more than a decade have adopted a 'partnership approach', including the involvement of the drinks industry, to addressing alcohol issues. Partnership has also been espoused in other countries – and indeed in the EU. In Ireland, however, the existence of a formal Social Partnership process, which has a significant social policy dimension, has given particular backing to the notion of partnership in relation to alcohol issues and has facilitated the input of the industry.

There are serious drawbacks to this approach. The desire to agree positions acceptable to all partners lessens the chances that strong policy positions will be adopted. Under the *Sustaining Progress* Partnership Agreement, for example, a Working Group on Alcohol Misuse was established – but its terms of reference precluded it from making the kind of recommendations in regard to pricing, availability and marketing that would have an impact on overall consumption. Furthermore, the partnership approach can give the impression that the Government is but one of several partners in

the task of addressing alcohol issues, rather than the body that has ultimate responsibility and authority for framing legislation and policy.

Role of Drinks Industry

The drinks industry has a strong presence in Ireland in terms of investment and employment. As is the case in other countries, as well as at a global level, the industry here has a vested interest in influencing policy on alcohol – and considerable resources to pursue this objective.

The industry argues that the 'misuse' of alcohol is not in its interest, and that it wishes to play a constructive role in regard to alcohol policy. It has set up and funds MEAS, which can be described as a 'social aspects organisation' of the type the alcohol industry has established in many countries (and at EU and global level) to represent the industry's interests in policy debate and to undertake information and education initiatives.[24]

However, the key policy areas in terms of reducing overall consumption – namely, increasing price, restricting availability and limiting marketing – must of necessity involve measures that are not in the interests of the alcohol industry. The industry has consistently displayed its opposition to such measures. It has strongly resisted legislation and regulations in these areas, has argued that it should be allowed to implement and monitor voluntary codes for self-regulation and has promoted policy options which research has shown to be of limited impact. Meanwhile, it has continued to vigorously market and promote alcohol and to maximise sales through reduced pricing.

At a fundamental level, then, there is an unavoidable clash between what must be the core aims of the alcohol industry – to sell its products and maximise its profits – and the demands of public health.

This reality needs to be acknowledged as a starting point in any dealings between government and the drinks industry regarding legislation and policy in respect of alcohol. The duty of government is to protect and promote the right to health of all its citizens, which it has guaranteed to do in signing up to international human rights agreements, such as the Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights. A further duty is to ensure the efficient use of limited health care resources – and this has to include taking steps to prevent levels of alcohol consumption that lead to illnesses and injuries which place additional demands on services.

Good News at Last?

In 2006, an Oireachtas Joint Committee proposed that alcohol should be included in a new 'national substance misuse strategy'– in other words, that there be a combined strategy to address issues relating to both alcohol and illicit drug use. Such an approach, the Committee said, 'would have the effect of cementing alcohol policy at the Governmental level.' [25]

The Committee reached its conclusion on the basis of arguments put forward in a consultants' report it had commissioned. This highlighted the absence of any permanent structures to give effect to recommendations of official reports on alcohol and the fact that, in contrast, there existed an explicit National Drugs Strategy and an accompanying integrated framework for implementation.[26] Within this framework, specific responsibilities regarding the Drugs Strategy are assigned at Cabinet, interdepartmental and departmental levels and there are in existence national, regional and local structures.

For a long time, there seemed little likelihood that this proposal would be accepted, in particular because the drinks industry strongly opposes such an approach. However, on 31 March 2009, it was announced that the Government had approved a proposal, brought to Government by the Department of Community, Rural and Gaeltacht Affairs and the Department of Health and Children, that there be 'a combined substance misuse policy to include alcohol and drugs'.[27]

After more than a decade of reports and recommendations but no officially defined policy and no implementation and accountability structures this seems a very positive development. Obviously, it will take time to develop and put in place a combined strategy. And it is more than likely that there will be concerted attempts to delay and modify the proposal.

Now is a time for those politicians, statutory organisations, voluntary and community groups, and ordinary members of the public who share a concern about the current impact of alcohol on Irish society to make known their desire that the

promised integrated strategy be put in place as soon as possible, and that the strategy be based on clear public health principles.

The development and implementation of the strategy will require determination and co-operation on the part of government ministers, and across different government departments and statutory agencies. The effectiveness of any strategy will ultimately depend on the willingness of the public to accept the kind of changes required if harmful alcohol consumption – one of the most pervasive and persistent of the country's health and social problems – is to be tackled.

Notes

1. Anushka Asthana and Jamie Doward, 'Binge Drinking: Do They Mean Us?', *The Observer*, Sunday, 21 December 2003.
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3. Björn Hibell, Ulf Guttormsson, Salme Ahlström, Olga Balakireva, Thoroddur Bjarnason, Anna Kokkevi and Ludwig Kraus,*The 2007 ESPAD Report: Substance Use Among Students in 35 European Countries*, Stockholm: The Swedish Council for Information on Alcohol and other Drugs, 2009. (www.espad.org)
4. *Ibid*., p. 73.
5. One standard drink is a half-pint of beer or ale, or a glass of wine, or a single measure of spirits.
6. *150 Years of the Annual Report of the Chief Medical Officer: On the State of Public Health 2008*, London: Department of Health, 2009.
7. Ann Hope, *Alcohol Related Harm in Ireland*, Dublin: Health Service Executive, 2008.
8. Department of Health, *National Alcohol Policy – Ireland*, Dublin: Stationery Office, 1996.
9. Strategic Task Force on Alcohol, *Second Report*, Dublin: Department of Health and Children, September 2004. The Task Force produced an *Interim Report* in May 2002.
10. Lila Rabinovich, Philipp-Bastian Brutscher, Han de Vries, Jan Tiessen, Jack Clift and Anais Reding, *The Affordability of Alcoholic Beverages in the European Union: Understanding the Link between Alcohol Affordability, Consumption and Harms*, Prepared for the European Commission DG SANCO, Cambridge: RAND Corporation, 2009, p. 27.
11. The Scottish Government, *Changing Scotland's Relationship with Alcohol*: *A Framework for Action*, Edinburgh: The Scottish Government, February 2009, p. 11.
12. *150 Years of the Annual Report of the Chief Medical Officer*, *op.cit*., p. 23.
13. Responsible Retailers of Alcohol in Ireland, 'RRAI Code Implementation', n. 7. (www.rrai.ie)
14. See Editorial, *The Irish Times*, 14 May 2009, commenting on the failure to introduce regulations under Section 9 of the Intoxicating Liquor Act 2008.
15. *Report of the Government Alcohol Advisory Group*, Dublin, 31 March 2008, par. 3.6, p. 11. (www.justice.ie)
16. Peter Anderson, Avalon de Bruijn, Kathryn Angus, Ross Gordon and Gerard Hastings, 'Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies', *Alcohol and Alcoholism*, January 2009, p. 1; p. 14.
17. Documentation obtained under the Freedom of Information Act by the National Youth Federation of Ireland and reported in the media supports the widespread view that this change followed representation by the drinks industry. (*The Irish Times*, 12 December 2005.)
18. The one Irish study on the impact of advertising found that children and teenagers under eighteen were not just very familiar with alcohol advertisements but ranked them as their favourites. The appeal of the advertisements for the young people lay not in the alcohol product being promoted but in the fact that they were stylish, action-filled, humorous, and portrayed a desirable lifestyle. See Cindy Dring and Ann Hope, *The Impact of Alcohol Advertising on Teenagers in Ireland*, Dublin: Health Promotion Unit, Department of Health and Children, 2001, p. 38.
19. Irish College of Psychiatrists, *Calling Time on Alcohol Advertising and Sponsorship in Ireland: Supporting a Ban on Alcohol Advertising in Ireland, Protecting Children and Adolescents*, Policy Paper Prepared by the Faculty of Addiction Psychiatry of the Irish College of Psychiatrists, September 2008. (www.irishpsychiatry.ie)
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24. See Peter Anderson,*The Beverage Alcohol Industry's Social Aspects Organizations: A Public Health Warning*, A Report for EUROCARE (The European Alcohol Policy Alliance), 2004. (www.eurocare.org)
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26. The Drugs Strategy has five 'pillars' – supply reduction; prevention (which includes education and awareness campaigns); treatment; research; rehabilitation.
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Irish Health Services
Money, Inequality and Politics

Sara Burke

Introduction

On 10 March 2009, the Minister for Health and Children, Mary Harney TD, said in the Dáil that emerging pressures on the finances of the Health Service Executive (HSE) would mean that savings of €480 million would have to be made elsewhere in its budget over the course of the year. The HSE, however, said on 12 March 2009 that in order to meet the new pressures and stay within budget it would have to make savings in other areas amounting to over €1 billion.

The divergence in the projections as to the scale of the shortfall went largely unnoticed by politicians, the media and the public. A month later, in a statement issued following the Supplementary Budget of 7 April 2009, the Minister for Health and Children referred to the shortfall as amounting to €540 million.[1]

This was reiterated in a further statement by the Minister on 24 April 2009, which said the figure was 'based on the best available information' and had been arrived at following 'a detailed examination undertaken by the HSE and the Department of Health and Children'.[2]

Dealing with the Shortfall

The statement of 24 April 2009 detailed how the shortfall was to be dealt with. Over €400 million would be accounted for by actions to be taken by the Department of Health and Children. The greater share of this would consist of measures that would channel additional revenue to the HSE and the rest of measures that would reduce the spending requirements placed on the HSE. The remaining €133 million of the shortfall would be accounted for by savings achieved by the HSE itself through 'measures … not affecting the Service Plan' of the HSE for 2009.

Despite an assurance in the Minister's statement that the priority would be 'to maintain, in every possible way, services to patients', it is inevitable that there will be cuts in services provided. The gap that has emerged in the HSE budget for 2009 may mean the difference between open and closed hospital wards; between older people and people with disabilities being able to live at home or being forced into residential care because of the lack of adequate home care services. It may mean the difference between promised and much-needed improvements being made or not made in health care for Travellers, in mental health services, in care for cystic fibrosis patients. The list could go on and on.

The scale of the difficulties facing the HSE budget, the fact that the Minister for Health and Children and the HSE initially gave different estimates of the size of the projected shortfall, and type of measures that have had to be taken in response, are not just significant in themselves. They are also a reflection of the confusion regarding aspects of the financing and obligations of the HSE that remained unresolved by the legislation under which it was statutorily established – the Health Act 2004.

Health Act 2004

With the 2004 Act, Mary Harney, at that point in position as Minister for Health and Children for just a few weeks, executed the reform which had been long planned by her predecessor, Micheál Martin TD.

Despite the two year lead-in to the establishment of the HSE, much of the detail of how it would operate remained unknown in late 2004. Contrary to the advice of both the Department of Finance and the Department of Health and Children, the Minister through the legislation handed over responsibility for the financial management of the HSE from the Secretary General of the Department of Health and Children to the CEO of the HSE.

The concern of the government departments in 2004 was that the HSE simply did not have the experience or expertise to manage the second largest public sector budget allocation in the State. And indeed for the first few years of its operation, the HSE, like the health boards before it, had to be bailed out by additional finance from the Central Exchequer.

However, in 2008, the HSE managed to live within its budget for the first time. Of course, this involved some juggling of internal budgets but this has always been the practice in Irish health finances and will take more time to curtail. Funds are moved from capital (buildings and equipment) to current (day-to-day) budgets, and from what are perceived as lower profile services (such as mental health and primary care) to higher profile areas (such as cancer services and acute hospitals).

HSE Service Plan 2009

A key reason, however, why the HSE succeeded in living within its budget in 2008 was that it introduced very strict 'cost cutting' initiatives in September 2007 and a range of measures which are referred to as the 'Value for Money' programme.

The HSE Service Plan for 2009, published just before Christmas 2008, provided for the delivery of the same level of services in 2009 as in 2008, despite the minimal increase allocated to the HSE in the October 2008 Budget.[3]

For decades, the Irish health system was under-funded ... services were starved of staff and resources

The Plan envisaged the continuance of the Value for Money measures adopted in 2008 and the achievement of yet more savings by reducing the overtime of junior hospital doctors; moving from the use of agency staff to salaried staff; making savings in travel, administration, and PR; continuing the shift from inpatient to day care in hospitals, and reducing hospital lengths of stay.

However, the Service Plan also acknowledged that there were factors which could affect the costs and the level of income of the HSE but which were outside its control. Listed among these were the increase in numbers entitled to medical cards, which is escalating as more and more people become unemployed; increased numbers on the Long Term Illness Scheme,[4] and an anticipated decline in income from the health levy.

Listed also were what the Plan described as other 'risks'. These included the €100 million the Government had said would be saved by the withdrawal of medical cards from people over seventy (the fact that the HSE described this as a 'risk' indicates that it believed there was little or no chance of this level of saving being achieved) and unknown actual costs of the revised consultants' contract.

In the event, as already noted, several of these anticipated pressures became a reality even within the first few months of 2009, giving rise to the projections of substantial shortfalls referred to earlier, and the corrective measures that have had to be taken.

Lack of Clarity

The whole episode reflects the contradictions inherent in the provisions of the legislation under which the HSE is established and the lack of clarity regarding the respective roles of the Department of Health and Children and the HSE. The Health Act 2004, in other words, laid the ground for the confusion that continues today. While the HSE must, by law, live within its budget, and the CEO of the HSE is responsible for managing that budget, many of the decisions and demands affecting the budget lie outside the authority of the HSE.

Thus, on the one hand, the HSE does not have control over the key elements of its income – specifically, the actual amount it is allocated in the Government's Budget each year, including the amount it receives from the health levy – as these are politically motivated and decided.

On the other hand, some of outgoings of the HSE are beyond its influence – for example, the changes in the cost of salaries under the new consultants' contract, and the costs associated with rising numbers becoming entitled to a medical card.

So what happens to the health budget now, given the international and national economic crises?

Still Making up for Decades of Neglect

For decades, the Irish health system was under-funded. From the early 1980s to the late 1990s, the services were starved of staff and resources. During this time, thousands of public hospital

beds were taken out of the system; buildings were allowed to slip into disrepair, and staffing levels did not keep in line with growing demand.

Since 1997, the budget for health has increased four-fold, from €4 billion then to a total budget allocation to health in 2009 of €16 billion. By any standards, this is an extraordinary increase. However, the enlarged budget for health is still just making up for the long years of neglect.

Some of the many official reports on health © JCFJ

Furthermore, the additional funding was poured into a system which was providing more and more services for a growing and ageing population (and currently a baby boom)[5] without major funding or structural reform.

While one could argue that the Irish health services have been over-reformed in the last five years, the reality is that this so-called 'reform' happened without changing the funding mechanism and, fundamentally, without introducing a universal health system, where access is based on need, not ability to pay.

Unique Public–Private Mix of Hospital Care

Ireland is unique in Europe in that we continue to privilege private patients over public patients within the public hospital system. It is remarkable that despite reform in the guise of the establishment of the HSE, the reconfiguration of hospitals, the recently-agreed consultants' contract, no attempt has been made to deconstruct the two-tier system of hospital care.

Most European countries have some type of public and private mix in health care, but Ireland is highly unusual in that a substantial part of private care takes place in public hospitals. This care is heavily subsidised by public money (up to 70 per cent) and private patients are allowed to skip the queue ahead of public patients.

One of the flagship projects of the current Minister for Health and Children has been the agreeing of a new contract for hospital consultants. When challenged about the two-tier nature of Irish hospital care, Ms Harney refers to the new contract as the solution.

The New Consultants' Contract

The new consultants' contract took almost five years to negotiate. It was delayed tactically by both sides – the doctors and the State. Report after report on the Irish health system had recommended that the issue of the public–private mix in consultants' contracts should be addressed. One of the three reports on reform of the health system published in 2003, the report of the *Commission on Financial Management and Control Systems in the Health Service* (the Brennan Report), stated:

Existing arrangements, which enable medical Consultants to combine their public hospital commitment with private practice, are inherently unsatisfactory from a management and control perspective. To address this, we recommend that all new public consultant appointments be on the basis of a commitment to work exclusively in the public sector.[6]

The new contract does not achieve this aim. Consultants are still allowed to opt for a public–private mix of work. By March 2009, about 85 per cent of consultants had signed up to the new contract. Of these, just 30 per cent had opted for Type A, which is the public-only contract. The remaining 70 per cent have a Type B or Type B* contract, both of which allow them to work publicly and privately.

A Type B contract enables consultants to practice in a public hospital and privately 'on site', i.e., in the private wards of the same public hospital or in a co-located private hospital.

It was planned originally that eight private for-profit hospitals would be built on the grounds of public hospitals. However, no co-located hospital is yet in place. There is now considerable uncertainty as to how many of these hospitals will ultimately be built – and when. This uncertainty is

reflected in the statement of the HSE Service Plan for 2009 that the projected progress during the year in the development of even the five co-located hospitals which are at a more advanced stage in planning would be 'subject to satisfactory banking arrangements'.[7]

Type B* contracts allow consultants to practice in a public hospital and off-site in a private hospital. Only consultants already working in the system can opt for this contract; in other words, anyone taking up a new contract from now on will not have this option. Over time, then, fewer and fewer consultants will hold this type of contract, so that eventually it will no longer be possible for a consultant employed in a public hospital to have a private practice other than in that hospital or in a co-located private hospital.

Terms and Conditions of the New Contract

Under the new contract, then, over two-thirds of consultants will continue to practice privately and publicly. They will be paid a salary for their work in providing services to public patients; for their private work, they will receive a fee per item of service (either in the form of payments from insurers or in direct out-of-pocket payments from patients). Every examination of the Irish health system has found that this mixed method of payment provides an incentive to engage in private work.

Under the old contract, the salaries paid to consultants for their public work ranged between €140,000 and €180,000. Under the new contract, the salary range is significantly higher – from €156,000 to €252,000. For the 70 per cent of consultants who have opted for one of the Type B contracts there will be, of course, additional earnings from private practice.

The salaries for the three main types of contract under the new scheme are:

Type A – public only: €211,000–€252,000;

Type B – public and private practice on the same site: €197,296–€205,000;

Type B* – public and private off-site: €156,000.

Minister Mary Harney has rejected the suggestion that the new salary scales represent a pay rise, saying that the new contract is about a new way of working – that it means a change in the work practices of consultants within the public system.

And this is in fact the case: under the new contract, consultants are expected to work a 37-hour week (under the old contract it was 33 hours); they will be rostered early in the morning, in the evenings and at weekends. Moreover, they will be accountable to newly-appointed 'Clinical Directors'.

Clinical Directors

Academic and government-commissioned reports have consistently highlighted the absence of accountability of consultants under the previous contract.

A. Dale Tussing and Maev-Ann Wren, for example, in their book, *How Ireland Cares*, commented: '… the consultants' common contract is widely criticised … Consultants are not accountable to anyone, either administratively or clinically…'. Tussing and Wren pointed to the serious management problems created by the 'extraordinary degree of autonomy' and the excessive delegation of responsibility to non-consultant hospital doctors which the common contract allowed.[8]

There is now considerable uncertainty as to how many co-located private hospitals will be built

The appointment of Clinical Directors and the fact that consultants will be directly accountable to them is therefore progress. However, no matter how it is viewed, it is clear that consultants will be paid significantly more for their new ways of working within the public system.

The Clinical Directors will also be responsible for ensuring that a common waiting list operates for all diagnostics and that the target of an 80:20 public–private ratio for public hospital beds is realised in practice. Clinical Directors are in the process of being recruited and appointed in Spring 2009. To qualify for appointment, candidates must already be a consultant; an additional sum of €50,000 will be paid on top of the consultant salary to those who fill the Clinical Director posts.

According to the Minister for Health and Children and the HSE, the new contract and the creation of the position of Clinical Director will end the privileging of private patients over public patients in public hospitals. Fundamentally, however, the public–private mix remains. All the international evidence shows that where there are incentives in place, private patients will continue to be privileged over public patients. Moreover, while the consultants' contract stipulates that there will be a common waiting list for diagnostics, there is nothing in the contract about a common waiting list for treatment.

And there is a way around the common waiting list for diagnosis – a patient could obtain a diagnosis in a private clinic or rooms not associated with a public hospital and then, since under the Health Ammendment Act, 1991 all citizens are entitled to care in a public hospital, could be referred as 'urgent' into the public hospital system (and skip the queue) or referred on to the consultant's list for private treatment in a public hospital (and skip the queue).

... the inequity arising from the public subsidisation of private care in public hospitals still remains unresolved

Furthermore, the inequity arising from the public subsidisation of private care in public hospitals still remains unresolved. The subsidisation consists of tax relief on insurance premia, and the fact that the full costs are not charged for the use of theatres, nursing staff, and hospital laboratories in the public hospitals where private care takes place. Over two decades, successive reports have recommended that public hospitals should be able to charge for the full cost of the private care taking place within them, but this has never been achieved.

Where the Political Parties Stand

Only when we have a universal health system where access to care is based on need, not ability to pay, will we see the ending of the two-tier structure of Irish hospital care.

While Fianna Fáil has not advocated such a system for about half a century, there is a growing consensus among opposition political parties about the need for one-tier, universal health care.

The Labour Party has long argued for a universal health system based on a social health insurance scheme.[9] Sinn Fein advocates a one-tier, tax-funded system akin to the National Health Service in place in Northern Ireland.

On 27 April 2009, Fine Gael, which had long been a proponent of the two-tier health system, published a policy document outlining proposals for a series of health service reforms, including the introduction of a system of universal health insurance based on the model operating in the Netherlands.[10] Fine Gael has therefore opted for a system of compulsory insurance using private insurance companies, under which the premia of people on lower incomes would be paid for or subsidised by the State, rather than a system of social health insurance where premia would be paid into a fund or funds run by the State.

The Green Party went to the electorate in 2007 advocating a universal health care system for all children, starting with under-sixes. The Party also said it would end the plan to co-locate private hospitals on the grounds of public hospitals. However, since going into coalition with Fianna Fáil and the now defunct Progressive Democrats, the Greens have done a u-turn on these commitments.

Both the Greens and Fianna Fáil backed the withdrawal (announced in the October 2008 Budget) of the element of universal health care represented by automatic medical card entitlement for all people over seventy. And while the Government capitulated to the anger of the grey lobby by drastically revising the original proposal, so that only 5 to 10 per cent of older people would lose their medical cards, it maintained the hard-line position that universal health care for this segment of the population would be abolished. Despite the demise of the Progressive Democrats as a political entity, their legacy in health is alive and well.

Only through the introduction of a universal, one-tier health system can access to health care be based on need, not ability to pay. In the decade when we had most, the divide between public and private care in the Irish health system widened considerably and as the decade ended one of the few examples of universality in the system was abandoned. It remains to be seen whether, in times

of less, there will be greater solidarity and the bold decision made to deliver a really good quality, universal public health system.

Notes

1. Department of Health and Children, 'Statement by the Minister for Health and Children following Supplementary Budget, 7th April 2009'. (http://www.dohc.ie/press/releases/2009/20090407.html)
2. Department of Health and Children, 'Statement by the Minister for Health and Children, Mary Harney T.D. on the HSE National Service Plan 2009', 24 April 2009. (http://www.dohc.ie/press/releases/2009/20090424.html)
3. Health Service Executive, *National Service Plan 2009*, Cork: Corporate Planning and Control Processes Directorate, HSE, 2008.
4. Under the Long Term Illness Scheme, people who have certain long-term conditions (including, for example, epilepsy, Parkinsonism, cerebral palsy, cystic fibrosis, mental handicap) but who do not qualify for a medical card can receive drugs, medicines and medical and surgical appliances for the treatment of that condition free of charge.
5. Between 1996 and 2008, the total population grew from 3,626,100 to 4,422,100 (estimated) – an increase of almost 800,000 or 20 per cent. In the same period, the population over 65 grew from 413,882 to 481,600 (estimated) – an increase of 16 per cent. There were around 72,000 births in 2008 as compared to 53,000 in 1999; the birth rate in 2008 was approximately 17.2 per 1,000 of population as compared to 14.3 per 1,000 in 1999.
6. *Commission on Financial Management and Control Systems*, Dublin: Stationery Office, 2003. (The Report is generally referred to as the Brennan Report, as the Commission was chaired by Niamh Brennan, Professor of Management, UCD.)
7. Health Service Executive, *op. cit*., p. 60.
8. A.Dale Tussing and Maev-Ann Wren, *How Ireland Cares: The Case for Health Care Reform*, Dublin: New Island, 2006, pp. 246–47.
9. For example, Labour Party, *Curing our Ills: Irish Healthcare 2000: Delivering Excellence for All*, Dublin: The Labour Party, 2000.
10. Fine Gael, *FairCare: Fine Gael Proposals to Reform the Health Service and Introduce Universal Health Insurance*, 27 April 2009. (www.faircare.ie)

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